Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SENDERO IMAGING & TREATMENT CENTER
7220 LOUIS PASTEUR DRIVE, SUITE 115
SAN ANTONIO TX 78229

Respondent Name

LUMBERMENS UNDERWRITING ALLIANCE

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0843-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Precert/preauth was requested it was withdrawn by Terry with Per-Cert Co. Corvel – as no preauth for initial MRI."

Amount in Dispute: $603.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is re-considering the provider bill and will supplement its response once the re-audit is completed to inform the Division and the provider of the results."

Response Submitted by: Lumbermens Underwriting Alliance, FOL, P.O. Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2010	Cervical MRI – CPT code 72141	$603.68	$603.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorized for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 14, 2011

- 808-Denied per carrier.
- 197-Payment adjusted for absence of precert/preauth.
- ODG-Services exceed ODG guidelines; preauth is required.

Issues

1. Did the disputed cervical MRI require preauthorization?
2. Does the ODG list the cervical MRI as treatment for claimant's condition?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed Cervical MRI based upon "197-Payment adjusted for absence of precert/preauth."

   28 Texas Administrative Code §134.600(p)(8)(A) states "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   Review of the submitted documentation finds that the disputed MRI was the initial MRI; therefore, preauthorization was not required. The insurance carrier's EOB denial of "197" is not supported.
2. The insurance carrier also raised the issue of "ODG-Services exceed ODG guidelines; preauth is required."

   The requestor submitted a physical exam report dated November 12, 2010 that indicates that claimant reported neck pain and numbness. The examination revealed decreased flexion and pain with rotation of neck. The assessment was a cervical strain with possible radiculopathy.

   The requestor also submitted a copy of cervical spine, left shoulder and left scapular x-rays performed on November 19, 2010 that did not reveal any fracture or significant abnormality.

   A review of the ODG identifies the following indicators for MRI:
   - "Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"."

   Therefore, the claimant's physical examination and x-rays findings were indicators for an MRI per the ODG.

3. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   The Division conversion factor for 2010 is $54.32.

   The services were rendered Bexar County.

   The MAR for CPT code 72141 in Bexar County is $650.65 (WC Conv 54.32/Medicare Conversion 36.8729 X $441.67 participating amount. The respondent paid $0.00. The difference between the MAR and amount paid is $650.65. The requestor is seeking $603.68; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 603.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $603.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/28/2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.